UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Civil No. 05md1726 JMR/AJB

In re: Medtronic, Inc. Implantable
Defibrillator Product Liability Litigation

ORDER ON FACT SHEETS

It is **hereby ordered** that the attached Plaintiff's Fact Sheet and the attached Defendant's Fact Sheet shall be the court approved facts sheets to be completed by the respective parties as instructed in the court's contemporaneously issued Pretrial Scheduling Order.

Dated: February 8, 2007

s/ Arthur J. Boylan
Arthur J. Boylan
United States Magistrate Judge

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

In re: Medtronic, Inc., Implantable Defibrillators Products Liability Litigation	MDL No. 05-1726 (JMR/AJB)
This Document Relates to All Actions	**PLAINTIFF'S FACT SHEET**

PLAINTIFF'S FACT SHEET

Each Plaintiff who was implanted with a Medtronic ICD or CRT-D must complete this Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If you cannot recall all the details requested, please provide as much information as you can. If the response to any question is that the person completing this Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). You may and should consult with your attorney, if you have any questions regarding the completion of this form.

If you are completing this form for someone who has died or who cannot complete the Fact Sheet for him or herself, please answer as completely as you can for that person. You may attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Caption: _____

2. Civil Action No.: _____

3. Court in which action originally brought (transferor district):

_____

4. Original civil action number in the transferor court. Civil Action No.: _____

5. Please provide the following information for all attorneys representing you.

_____
Name

_____
Firm

_____
Street Address

_____
City, State and Zip Code

_____ _____
Telephone number Fax number

_____
E-mail address

-and-

_____
Name

_____
Firm

_____
Street Address

_____
City, State and Zip Code

_____ _____
Telephone number Fax number

_____
E-mail address

B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

1. _____

Your Name

_____

Street Address

_____

City, State and Zip Code

2. In what capacity are you representing the individual:

_____

3. If you were appointed by a court, state the:

_____ _____

Court Date of appointment

4. Your relationship to deceased or represented person:

_____

a. If you represent a decedent's estate, state the date of death and cause of death of the decedent.

_____

_____

5. If you represent a decedent's estate, provide a copy of the decedent's death certificate and autopsy report (if conducted).

C. If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who received a Medtronic ICD. Those questions using the term "You" refer to the person who received an implantable defibrillator. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

1. Have you ever been defibrillated by the Medtronic ICD at issue in your Complaint?

Yes _____ No _____

2. Do you claim that you have suffered a bodily injury as the result of the use of a Medtronic ICD?

Yes _____ No _____

3. If the answer to the foregoing questions is "Yes", state the nature of the injury or injuries which you claim.

_____

_____

D. If you do not claim you have suffered a bodily injury as the result of the use of a Medtronic ICD, state how you have been injured or describe the losses you are claiming.

_____

_____

II. PERSONAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

B. Maiden or other names used or by which you have been known, including alias/nicknames:

_____

C. Current Address: _____
Street

_____
City State Zip Code

D. How long have you lived at this address? _____

E. Current or last employer:

_____
Name

_____
Address

_____

Dates of Employment

_____

Job Title

F. Social Security Number: _____

G. Date and Place of Birth:_____

H. Sex: Male _____ Female _____

I. Have you ever filed a worker's compensation claim?

Yes _____ No _____

If "yes," please state:

1. Year claim was filed: _____

2. Where claim was filed: _____

1. Claim/docket number, if applicable: _____

2. Nature of disability: _____

3. Period of disability: _____

6. Address of Claims Office:_____

_____

7. Whether the claim was settled and amount of any settlement:

_____

[Attach additional sheets if necessary to describe more than one claim]

J. Have you ever filed a social security disability claim?

Yes _____ No _____

If "yes," please state:

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Nature of disability: _____

4. Period of disability: _____

5. Monthly amount of any disability payments: _____

6. Address of Claims Office:_____

_____

7. Amount of any lump sum settlement: _____

[Attach additional sheets if necessary to describe more than one claim]

K. Have you ever filed a lawsuit or made any other type of claim, other than in the present suit, relating to any bodily injury?

Yes _____ No _____

If "yes," please complete the following for each lawsuit or other claim:

1. Year lawsuit/claim filed:_____

2. Court in which filed:_____

3. Civil Action or Docket Number:_____

4. Nature of claim:_____

5. Did you give testimony either in deposition or at trial?_____

L. Has any insurance or other company provided medical coverage to you (either directly or through a group including any employer of yours) or paid medical bills on your behalf at any time, beginning five (5) years before your alleged injury in this lawsuit through the present?

Yes _____ No _____

III. FAMILY INFORMATION/MARITAL STATUS

A. Are you currently married?

Yes _____ No _____

B. Has your spouse filed a loss of consortium claim?

Yes _____ No _____

C. Spouse's name: _____

D. Spouse's date of birth: _____

E. Spouse's social security number: _____

F. Spouse's occupation: _____

G If not currently married, do you have any former spouses who have filed loss of consortium claims?

Yes _____ No _____

H. If any former spouses have filed loss of consortium claims, please provide:

1. Name of former spouse: _____

2. Date of birth of former spouse: _____

3. Date of marriage to former spouse: _____

4. Date of dissolution of marriage from former spouse: _____

IV. YOUR MEDICAL BACKGROUND

A. Age: _____

B. Height: _____

C. Current weight: _____

D. Condition for which the Medtronic ICD was indicated:

_____

E. Current status of condition for which the Medtronic ICD was implanted:

_____

_____

F. Have you had any of the following tests or procedures in the past 10 years?

Electrophysiology study: Yes ___ No ___ I don't know ___

Cardiac Catheterization: Yes ___ No ___ I don't know ___

If "yes," please complete the following for each test identified above. If you cannot remember all the details, please list as much information as you can.

a. Type of test: _____

b. Date administered: _____

c. Reason for test: _____

d. Facility name & address: _____

_____

e. Ordering doctor: _____

f. Results/diagnosis: _____

[Attach additional sheets if necessary to describe each test]

V. OTHER MEDICAL INFORMATION

A. To the best of your knowledge, have you ever been told by a doctor or any other health care provider, that you have, may have or had any of the following:

1.	Hypertension or high blood pressure	Yes ____ No ____
2.	Heart valve problems (lesions, prolapse, regurgitations, sclerosis, stenosis)	Yes ____ No ____
3.	Heart attack	Yes ____ No ____
4.	Stroke of any type	Yes ____ No ____
5.	Any kind of blood clot	Yes ____ No ____
6.	Pulmonary embolism	Yes ____ No ____
7.	Congenital abnormality of heart	Yes ____ No ____
8.	Immune system disease or dysfunction (including Aids or HIV)	Yes ____ No ____
9.	Rheumatic fever	Yes ____ No ____
10.	Cirrhosis, hepatitis or other liver disease	Yes ____ No ____
11.	Alcoholism	Yes ____ No ____
12.	Cancer(s) If yes, specify: _____	Yes ____ No ____
13.	Pulmonary hypertension	Yes ____ No ____
14.	Neurological problem If yes, specify: _____	Yes ____ No ____

15. Cardiac arrhythmias Yes ____ No ____

16. Endocarditis Yes ____ No ____

17. Any cholesterol problem Yes ____ No ____
If yes, specify : _____

18. Diabetes mellitus or other form of diabetes Yes ____ No ____
If yes, specify the type: _____

19. Kidney disease Yes ____ No ____

20. Any connective tissue disease Yes ____ No ____
(e.g. Marfan's, Lupus or Arthritis)

21. Other autoimmune disease Yes ____ No ____
If yes, specify: _____

22. Thyroid disorder Yes ____ No ____

23. Coronary artery disease Yes ____ No ____

24. Other heart or lung disease Yes ____ No ____

25. Gum disease, tooth infection or abscess Yes ____ No ____

26. Transient ischemic attack (TIA) Yes ____ No ____

27. Hypotension (low blood pressure) Yes ____ No ____

28. Carotid artery disease Yes ____ No ____

29. Aortic aneurysm Yes ____ No ____

30. Urinary infection Yes ____ No ____

31. Syncope Yes ____ No ____

32. Light-headedness Yes ____ No ____

33. Dizziness Yes ____ No ____

34. Sudden cardiac death Yes ____ No ____

35. Cardiomyopathy (hypertensive, ischemic) Yes ____ No ____

36. Neuromuscular diseases (muscular dystrophy, etc.) Yes ____ No ____

37. Bradycardia Yes ____ No ____

38. Tachycardia Yes ____ No ____

B. If you responded yes to any of the above, please identify the condition, the date of onset and state the name of the physician or other person and, if not provided in the accompanying list, the address of the physician who made the diagnosis or informed you of the condition.

1. Condition: _____
   Onset: _____
   Name and address of diagnosing physician or other person:
   _____
   _____

2. Condition: _____
   Onset: _____
   Name and address of diagnosing physician or other person:
   _____
   _____

3. Condition: _____
   Onset: _____
   Name and address of diagnosing physician or other person:
   _____
   _____

[Attach additional sheets if necessary to describe each condition]

C. State the name and address of your current family/primary care physician:

_____

_____

D. State the name and address of each of your family/primary care physicians going back 10 years: _____

_____

_____

E. State the name and address of each cardiologist, cardiac electrophysiologist, cardiac surgeon and/or thoracic surgeon that has ever seen or treated you: _____

_____

_____

_____

F. State the name and address of each hospital, surgery center or other facility of any kind including mental health facilities, where you have ever received treatment in the last 10 years: _____

_____

_____

G. State the name and address of each other physician or healthcare provider of any kind from whom you ever received treatment in the last 10 years:

_____

_____

H. State the name and address of each pharmacy, drugstore or any other facility where you ever received any prescription medication in the last ten years: _____

_____

_____

VI. IMPLANT/EXPLANT

A. If you received a Medtronic ICD, for which you have made a claim of injury, please state:

1. The date of implantation: _____

2. Name and address of the doctor who told you that you need to have an ICD implanted and/or the prescribing physician:

_____

_____

3. The name and address of the implanting surgeon: _____

_____

_____

4. The specific make, model, lot number and serial number of the Medtronic ICD you received: _____

_____

_____

5. Name and address of hospital where implant was conducted:

_____

_____

B. After your Medtronic ICD was implanted, did you participate in regular follow-up visits with your doctor(s)?

Yes ____ No ____ I don't know ____

If "yes," please complete the following:

1. How often did you follow up with your doctor(s) about your Medtronic ICD: _____

_____

2. During this follow up, was your Medtronic ICD ever tested by a doctor?

Yes ____ No ____ I don't know ____

If "yes," please complete the following:

a. Dates of testing: _____

_____

b. Location of testing: _____

_____

c. Testing by (name & address): _____

_____

d. Results of testing, if you know: _____

_____

C. Were you given any written instructions, warnings or other information regarding the implantation of the Medtronic ICD?

Yes ____ No ____ I don't know ____

1. If "yes," when did you receive the information: _____

2. Who gave you the information? _____

3. Do you have the written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

Yes ____ No ____ I don't know ____

4. If you no longer have the written information in your possession, please describe the information that you received to the best of your ability. _____

_____

_____

D. Were you ever given any oral instructions, warnings or other information regarding your Medtronic ICD?

Yes ____ No ____ I don't know ____

1. If "yes," when did you receive those instructions? _____
2. Who gave those instructions to you?_____
3. Please describe the oral instructions you received to the best of your ability: _____

_____

_____

E. If you had your Medtronic ICD explanted, please state:

1. The date of explant: _____
2. The reason for the explant: _____
3. The name and address of the explanting surgeon: _____

_____

_____

4. Name and address of hospital where explant was conducted: _____

_____

_____

5. The present location of the explanted ICD: _____

_____

_____

6. If your explanted Medtronic ICD has not been returned to Medtronic, has it been tested?

Yes ____ No ____ I don't know ____

a. If "yes," when was it tested? _____

b. Dates of testing: _____

c. Location of testing: _____

d. Tested by (name & address): _____

_____

_____

e. Results of testing, if you know: _____

_____

7. During your explant surgery, was a replacement ICD implanted?

Yes _____ No _____

If "yes," state the manufacturer, make, model, lot number and serial number of the replacement ICD: _____

_____

_____

8. Did you pay for the explant surgery and the replacement ICD?

Yes _____ No _____

9. If not, state who paid for the explant surgery and the replacement ICD: ___

_____

_____

F. If you have not had your ICD explanted, do you presently plan to have the device explanted?

Yes _____ No _____

If "yes," please complete the following:

1. The date scheduled for explant surgery: _____

2. The name of the explanting surgeon: _____

3. The name and address of the hospital where the explant surgery will be performed: _____

_____

_____

4. The reason for the explant surgery: _____

_____

5. Whether it was explanted or not - has any doctor ever told you that you need to have your Medtronic ICD explanted?

Yes _____ No _____

If "yes," provide name and address of each such doctor:

_____

_____

6. Whether it was explanted or not - has any doctor told you that your medical condition prevents you from having your Medtronic ICD explanted?

Yes _____ No _____

If "yes," please provide the name and address of each such doctor:

_____

_____

G. If you presently have an implanted defibrillator and/or pacemaker, please state the manufacturer, make, model, lot number and serial number of that device. _____

_____

_____

VII. ALLEGED INJURIES AND DAMAGES

A. If you are making a claim for physical injuries or illness as a result of your Medtronic ICD, please describe the following:

1. Nature of physical injuries or illness: _____

_____

_____

2. The date you first became aware of the physical injuries or illness alleged in the complaint.

_____

_____

3. How did you first became aware of the physical injuries or illness alleged in the complaint:

_____

_____

4. Are those injuries or illness continuing?: _____

5. Did you see a doctor, clinic or other healthcare provider for the physical injuries or illness listed above?

Yes ____ No ____ I don't know ____

B. If you claim psychological or emotional injury as a consequence of having a Medtronic ICD, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of a Medtronic ICD.

Yes _____ No _____

If "yes," please complete the following:

1. Name and address of each person who treated you:

a. _____
Name

_____
Address (if not otherwise provided)

_____

b. _____
Name

_____
Address (if not otherwise provided)

_____

c. _____
Name

_____
Address (if not otherwise provided)

_____

2. Condition for which treated

_____

_____

3. When treated

_____

VIII. LOSS OF INCOME

A. If you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition which you believe was caused by your Medtronic ICD:

1. Complete the following information with respect to your employment for the past five years.

Employers for Past Five Years	Address	Position	Dates of Employment

Employers for Past Five Years	Address	Position	Dates of Employment

2. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your Medtronic ICD and the amount of income which you lost:

_____

_____

3. State your earned income for each of the last five years.

Year	Income
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

IX. MEDICAL AND OUT-OF-POCKET EXPENSES

A. State the amount of medical expenses you have paid or incurred, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of a Medtronic ICD for which you seek recovery in this action. $_____

B. If you are making claims from out-of-pocket expenses as a result of the affected product, please complete the following:

1. What are the expenses for? _____

2. Amount of fees or expenses: _____

X. DOCUMENT REQUESTS

Attach the following documents to this Fact Sheet, to the extent that such documents are currently in your possession or the possession of your lawyers**:**

1. A copy of all medical records from any physician, hospital or health provider who treated you for any injury, illness and/or disease that you identified in response to any section of this Fact Sheet.

   Attached _____ Not Applicable _____ Don't Have _____

2. All documents referring to or relating to your medical history over the past ten years.

   Attached _____ Not Applicable _____ Don't Have _____

3. All documents, including but not limited to, literature and/or warnings, received by you relating to any Medtronic ICD from any source.

   Attached _____ Not Applicable _____ Don't Have _____

4. Each informed consent form signed by you in connection with treatment by a health care professional and/or institution relating to any Medtronic ICD whether manufactured by Medtronic or any other company.

   Attached _____ Not Applicable _____ Don't Have _____

5. All reports of any testing, including drafts and raw data, conducted on the Medtronic ICD that is the subject of your claim in this litigation.

   Attached _____ Not Applicable _____ Don't Have _____

6. All x-ray images depicting the location of the Medtronic ICD.

   Attached _____ Not Applicable _____ Don't Have _____

7. All documents relating to your insurance coverage that are applicable to the illness, injury or medical condition which forms the basis of your Complaint, including any application to any insurer for coverage whether insurance was obtained or not.

   Attached _____ Not Applicable _____ Don't Have _____

8. All written, recorded or transcribed statements concerning this action made by any parties or witnesses, or their respective agents, servants or employees.

   Attached _____ Not Applicable _____ Don't Have _____

9. All documents referring or relating to your claimed damages.

   Attached _____ Not Applicable _____ Don't Have _____

10. All documents submitted to or received from the Social Security Administration, any

workers' compensation agency, or any disability insurer concerning any disability claim you have made during the past ten years.

Attached _____ Not Applicable _____ Don't Have _____

11. If you are making a claim for loss of earnings or loss of earnings impairment, your state and federal tax returns for the last five (5) years and your employment records for the last five (5) years.

Attached _____ Not Applicable _____ Don't Have _____

12. All press releases or other public statements made by you relating to this litigation or to your illness, injury, or medical condition that forms the basis of your Complaint.

Attached _____ Not Applicable _____ Don't Have _____

13. Authorizations for the release of medical, insurance, employment, Worker's Compensation, social security, and disability records for those entities identified in the above responses.

Attached _____ Not Applicable _____ Don't Have _____

XI. AUTHORIZATIONS

Complete and sign the attached Authorizations for Release of medical, insurance, employment, social security, and internal revenue service.

If you have filed a Workers' Compensation or Social Security Disability Claim, please complete and sign the attached Authorization for Release of Workers' Compensation and Social Security Records

DECLARATION

I declare under penalty of perjury under the laws of the United States of America that all of the information provided in Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief. I further declare that I have supplied all the documents requested in part IX of this Plaintiff's Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied authorizations for the release of medical, employment, insurance and disability records for those entities identified in these responses.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

_____ _____

Signature Date

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

In re: Medtronic, Inc. Implantable Defibrillators Products Liability Litigation	MDL No. 05-1726 (JMR/AJB)
This Document Relates to All Actions	**DEFENDANT'S FACT SHEET**

For each Plaintiff from whom it has received a completed and verified Plaintiff Fact Sheet ("PFS") and completed authorizations thereto, Defendant Medtronic, Inc. ("Medtronic") must complete this Defendant Fact Sheet ("DFS"). Medtronic shall serve a complete and verified DFS within forty-five (45) days after receipt of a completed and verified PFS and the completed authorizations. The DFS must be answered and served in accordance with the Pretrial Schedule ordered by the Court. Medtronic should attach additional sheets of paper if that is necessary to completely answer the following questions.

I. CASE INFORMATION

This Defendant Fact Sheet pertains to the following case:

Case caption: _____

Civil Action No.: _____

Court in which action was originally filed: _____

Name and address of all person(s) who provide information responsive to the questions posed in this Fact Sheet.

_____

II. CONTACTS WITH IMPLANTING HEALTHCARE PROVIDER

In Plaintiff's Fact Sheet, Plaintiff identified persons who prescribed or implanted the Medtronic implantable cardioverter defibrillator (ICD) or cardio resynchronization therapy defibrillator (CRT-D) to Plaintiff (hereinafter "Implanting Healthcare Provider"). For each

Implanting Healthcare Provider identified, please state and, where requested, provide the following:

A. Dear Doctor or Dear Healthcare Provider Letters

1. For each "Dear Doctor" or "Dear Healthcare Provider" letter that you contend was actually sent to Plaintiff's Implanting Healthcare Provider, regarding the device for which Plaintiff seeks recovery, please: (a) identify the letter sent; (b) state the date that each letter was actually sent to Plaintiff's Implanting Healthcare Provider, (c) state the person to whom each letter was actually sent; (d) state the address where it was sent; (e) identify the database or documents that demonstrate these facts; (f) identify the persons who provided information responsive to this request.

_____

_____

_____

_____

NOTE: Please attach hereto a copy of each letter allegedly sent to Plaintiff's Implanting Healthcare Provider.

2. In addition, identify any professional information request letters regarding the device for which Plaintiff seeks recovery that you contend were actually sent to the Plaintiff's Implanting Healthcare Provider identified in Plaintiff's Fact Sheet within the relevant time period set forth above. Please also identify: (a) the date that each letter was sent to Plaintiff's Implanting Healthcare Provider; and (b) the address where each letter was sent.

_____

_____

_____

_____

B. Other Contacts

1. For each Implanting Healthcare Provider identified, identify the Medtronic Sales representative(s) responsible for the patient's account and produce the following information:

Plaintiff's Implanting Healthcare Provider: _____

Address: _____

Name of each Medtronic representative(s) responsible for the patient's account:

_____

Current Relationship, if any, between Medtronic and the sales representative:

_____

_____

_____

_____

2. Has Plaintiff's Implanting Healthcare Provider(s) ever contacted you through Medtronic's website or Medtronic's toll-free phone number to request information concerning the device for which Plaintiff seeks recover, its effect, its risk, or whether it should be explanted?
☐ Yes ☐ No

If your answer is "yes," please identify and attach any document which refers to your communication with Plaintiff's Implanting Healthcare Provider(s) concerning the device for which Plaintiff seeks recovery.

III. PLAINTIFF'S PRESCRIBING AND IMPLANTING HEALTHCARE PROVIDER'S IMPLANTING PRACTICES.

In Plaintiff's Fact Sheet, Plaintiff identified his or her implanting Healthcare Provider(s). For each Implanting Healthcare Provider state and produce the following:

1. Do you have or have you had access to any database or any information which tracks any of Plaintiff's Implanting Healthcare Providers prescribing or implanting practices with respect to Medtronic ICDs or CRT-Ds, the number of ICDs and/or CRT-Ds, the number of replacements, and the timeframe when these devices where prescribed and/or implanted? ☐ Yes ☐ No

If your answer is "yes," please produce or identify the database and document which captures that information.

IV. PLAINTIFF'S MEDICAL CONDITION

1. Have you been contacted by Plaintiff, any of his/her physicians or anyone on behalf of Plaintiff through Medtronic's website or Medtronic's toll-free phone number concerning Plaintiff, excluding litigation-related inquiries by Plaintiffs or Claimants? ☐ Yes ☐ No

   If you answer is "yes," please (a) state the name of the person(s) who contacted you, (b) state the person(s) who was contacted including their name, address and telephone number and, (c) produce or identify any and all documents which reflect a communication with any person and you concerning Plaintiff.

2. Please produce a copy of any MedWatch form regarding the device for which they seek recovery which would further reflect or relates to the Plaintiff, including any back-up documentation concerning Plaintiff and any evaluation you did concerning the Plaintiff.

3. Did you advertise Medtronic defibrillators and pacemakers in the media market in which Plaintiff lived at the time he or she was implanted with the Medtronic defibrillator/pacemaker? ☐ Yes ☐ No

   If your answer to the preceding question is "yes," identify the identity of the media outlet, and the dates that the advertisements ran.

Identity of Advertisement and Intended Media Marketplace	Nature of Media (print or television)	Identity of the Media Outlet	Dates Advertisements Ran

Please provide or identify true and accurate copies of advertisements identified above.

4. Did you advertise Medtronic pacemakers or defibrillators in the media market in which Plaintiff's Implanting Healthcare Provider's office was located at the time Plaintiff was implanted with the Medtronic defibrillator/pacemaker? ☐ Yes ☐ No

5. If your answer to the preceding question is "yes," please identify the identity of the media outlet and the dates that the advertisements ran.

Identity of Advertisement and Intended Media Marketplace	Nature of Media (Print or Television)	Identity of the Media Outlet	Dates that Advertisements Ran

Please provide or identify true and accurate copies of advertisements identified above.

V. PLAINTIFF'S DEVICE

1. State whether you have received information concerning the interrogation of Plaintiff's device subsequent to its implant in Plaintiff. If your answer is yes, provide all such information.

_____

_____

2. State whether you now have, or ever have had, access to, Plaintiff's device subsequent to its explant from Plaintiff. If your answer is yes, state whether you presently have Plaintiff's device. If so, where is it.

_____

_____

3. State whether you have conducted any testing on plaintiff's device. If so, identify each test performed on Plaintiff's device, the date of such test, the person who conducted such test, and the results of the test (including the detailed data obtained from such test).

_____

_____

4. State whether you determined whether Plaintiff's device failed. If so, please describe the failure mode, if known.

_____

_____

5. State whether you have formed any opinions on whether Plaintiff's device fell beneath Defendant's design or manufacturing standards for such device. If your

answer is yes, state in what way the device fell beneath such standards.

_____

_____

VI. DOCUMENTS

To the extent you have not already done so, produce a copy of all documents and things that fall into the categories listed below. These include documents in your possession or in possession of any of your present and former employees including information provided to your attorneys:

1. Any letters or standardized documentation which relates or refers to Plaintiff;

2. Any letters or standardized documentation sent to or received from any of Plaintiff's Implanting Healthcare Provider or explanting physicians, if identified in PFS, regarding the device for which Plaintiff seeks recovery;

3. Any letters or standardized documentation reflecting any actual communication between you and Plaintiff's implanting physicians or explanting physicians concerning the risks associated with the device for which Plaintiff seeks recovery;

4. Any letters or standardized documentation reflecting any actual communication between you and Plaintiff's implanting or explanting physicians, if identified in PFS, concerning the reasons to explain the defibrillator/pacemaker;

5. Any MDR, MedWatch, or Vigilance report that was filed concerning Plaintiff's device;

6. Any Health Risk Assessment Report and event or incident investigation file concerning Plaintiff's device; All data received when you were first notified that Plaintiff was implanted with a Medtronic device including: type of device, serial number of device, implanting physician, hospital where implant occurred, Plaintiff's identifying information (name, address, Social Security number);

7. State whether you have received information concerning the interrogation of Plaintiff's device subsequent to its implant in Plaintiff. If your answer is yes, provide all such information;

8. State whether you now have, or ever have had, access to, Plaintiff's device subsequent to its explant from Plaintiff. If your answer is yes, state whether you presently have Plaintiff's device. If so, where is it;

9. State whether you have conducted any testing on Plaintiff's device. If so, identify each test performed on plaintiff's device, the date of such test, the person who conducted such test, and the results of the test (including the detailed data obtained from such test);

10. State whether you have formed any opinions on whether Plaintiff's device fell beneath Defendant's design or manufacturing standards for such device. If your answer is yes, state in what way the device fell beneath such standards.

I declare under penalty of perjury subject to the 28 U.S.C. § 1746 that all the information provided in this DFS is true and correct to the best of my knowledge and that I have supplied or requested documents to the extent that such documents are in my possession, custody and control (including the custody and control of my lawyers).

Dated: _____ _____

Name